Toward a Sociological Understanding of Complementary and Alternative Medicine Use

Terry D. Stratton, Ph.D., 1 and Jennifer L. McGivern-Snofsky, M.A. 2

Abstract

Background and objectives: The wide array of treatments and modalities comprising complementary and alternative medicine (CAM) represent a growing option for many individuals. Seeking to better understand this, much research has centered on identifying sociodemographic (e.g., age, gender, race) or social–psychologic (e.g., absorption, depression, coping) correlates of using CAM therapies. In contrast, sociological perspectives recognize the influence of larger-scale, external forces on individuals' motivations to seek alternative or complementary care.

Aim: This paper, then, illustrates current and potential sociological approaches to understanding CAM use, and the importance of social forces that influence persons' decisions to utilize (or not) “unconventional” medical care.

Introduction

Understanding complementary and alternative medicine use: Current approaches

Complementary and alternative medicine (CAM)—and the numerous modalities it entails—continues to be an increasingly popular option for persons seeking relief from or prevention of a wide range of bodily complaints, ailments, and illnesses. 1-5 CAM was defined by the National Center for Complementary and Alternative Medicine (NCCAM) as “a group of diverse medical and health care systems, practices, and products that are not presently considered to be part of conventional medicine,” 6 and a 2002 study by the Centers for Disease Control and Prevention found 36% of U.S. adults to be currently using some form of CAM therapy. 7

Given the recent emergence of related research, many investigators have focused on identifying sociodemographic correlates of individuals' use of a CAM therapy. While not all findings concur, variables such as age, race, gender, education, income, geographic residence, and disease state/health status have been linked to the use of a CAM modality. Employment and insurance status have also been found to be significant correlates, and further research has documented varied usage among individuals of different sexual orientations. 27

A limitation of such studies is their emphasis on correlates of prevalence rather than on explanatory factors. Thus, a parallel line of inquiry has focused on identifying non-sociodemographic correlates of CAM use: namely, social–psychologic variables such as absorption, depression, coping, quality of life, risk-taking, risk perception, social support, and specific personality domains. 29,34

Finally, factors influencing individuals' decisions to use various “unconventional” medical therapies have been examined. For example, results suggest that use of a CAM treatment derives from dissatisfaction with allopathic medicine, although this finding remains mixed (see, for example, Furnham and Kirkcaldy). Studies have also shown a need for greater personal control in the treatment process, conventional medicine's ineffectiveness, and a desire to avoid undesirable side effects. A 2004 NCCAM study found that 28% of adult users of CAM modalities were motivated by uncertainties about the efficacy of conventional medicine, while 13% were detracted by the relative cost of such treatments—a concern borne out in other studies.

To supplement these approaches, we will discuss CAM use from a sociological perspective. Examined within this broader vantage point, the use of CAM therapies may be viewed sociologically: that is, as individual actions (agency) influenced by external social forces (structure). Toward this end, we describe macro- (e.g., CAM as a profession) and micro-level (e.g., CAM as individual meaning) perspectives on

1Department of Behavioral Science, University of Kentucky College of Medicine, Lexington, KY.
2Department of Sociology, University of Washington, Seattle, WA.
CAM, and postulate how key findings from general CAM research might be interpreted within a sociological framework.

Applying any theoretical perspective to the topic at hand runs the risk of grossly oversimplifying complex and multidimensional phenomena. For example, individuals’ use of CAM modalities—as a discrete behavior—may be the result of myriad forces weighed within a complicated decision-making process. Similarly, the aggregation of distinct modalities under the “CAM” rubric downplays the diverse systems of beliefs, medicines, and philosophies underlying various approaches. Thus, although a discussion of individual modalities is not possible, a “societal” focus should in no way detract from the diversity and complexity that differentiates CAM systems.

Sociological perspectives

Writing in the late 1950s, sociologist C. Wright Mills43 lamented individuals’ inabilitys to connect their personal experiences with distant, often impersonal social and historical forces. Only by exercising one’s sociological imagination, he contended, could seemingly personal actions, circumstances, and problems be truly understood: that is, by viewing them not in isolation, but as part of the larger context of external forces within which they were shaped.43

Thus, using Mills’ terminology, sociological thought can be applied along a continuum ranging from a private problem to a public issue; in other words, from the actions, thoughts, or attitudes of an individual (or group of individuals) to the roles of large-scale social organizations (i.e., medicine) within modern, industrialized nations. This translates into understanding why individuals use CAM therapies to why such modalities are considered “unconventional.” We begin with the former.

Micro-level approaches. As individuals traverse their daily lives—engaging in activities ranging from the routine to the episodic—they are compelled to seek out experiences that hold meaning. Such experiences differ among persons and reflect, among other things, the social roles occupied, the salience of identities, and the desired sense(s) of self.44 Implicated in individuals’ social meanings are their definitions of health, illness, and associated health beliefs, which are dramatically recast within specific CAM modalities.45 Indeed, examining individuals’ spirituality, religion, health effort/control, and personal openness relative to CAM use, Hildreth and Elman46 have concluded: “For users with certain health beliefs, including spiritual or religious worldviews, CAM and even conventional service does not take place outside this system of belief.”

Similarly, research examining health beliefs within a sociobehavioral framework found that such predisposing factors (e.g., health-awareness, treatment of the whole person) were key predictors of CAM use.35,47 In another study, attitudes and subjective norms were found to predict individuals’ intentions to use homeopathy.48 Recognition of the importance of health beliefs and attitudes related to CAM have hastened the development of validated measures of each.49,50

Using a more inductive, qualitative approach, Foote-Arda,51 in her study of human immunodeficiency virus–positive persons, found that meanings associated with CAM use helped patients negotiate and manage the social implications of their illness. Conversely, CAM use was constrained by patients’ inabilitys to incorporate unconventional treatments into their health strategies.52 An openness to new experiences,48 differing epistemological frameworks for assessing evidence,53 or the simple incongruence of envisioning an acupuncture patient (for example) within one’s “possible selves”54 may all weigh heavily in individuals’ CAM use.

Macro-level approaches. Whereas some sociological research has tended to emphasize the role of the individual in understanding CAM use, other studies have used a more macro-structural approach to understanding the emergence and growth of CAM therapies. Much of the work has conceptualized CAM as a social movement, focusing largely on professionalization and its resulting advantages (e.g., respect, prestige, legitimacy, etc.).

For example, Goldstein55 has argued that much of CAM’s success within the medical marketplace hinges upon its allegiance with “legitimate” power-brokers and the adoption of shared economic and political goals. Other people have posited, also from a macrostructural perspective, that the popularity of CAM may be linked to an emergent (and congruent) set of postmodem values.56 This new value structure, it is suggested, poses a challenge to the central role of science in modernity, and offers an opportune entre for diverse and varied alternatives to health and health care.57

However, macro-structural approaches vary in their perspectives. Dworkin,58 drawing a historical parallel between medicine and religion, and the “science of belief” central to each, argues that important changes in both have caused their declining influence. Drawing upon a religious tradition once shared by medical practitioners, the emergence of CAM now provides patients with acceptable ways to “make their pain and misery more comprehensible.” “Alternative medicine,” he suggests, “has simply taken up what the modern medical profession has thrown away.”

In yet another approach, stakeholders actively work to align themselves and their organizations within the changing structural forces of the times. Winnick,59 building upon early work on medical professionalization,60 traced the professional evolution of CAM through three distinct phases: condemnation, reassessment, and integration. In this latter phase, she postulates, the emergence of “integrative medicine” within the medical profession may signal the final stage of this struggle: cooperation. Welsh and her associates61 found that Canadian CAM practitioner groups’ strategies centered on the organization and transmission of knowledge bases, and included concerted efforts to improve educational and practice standards, bolster peer-reviewed research, and increase group cohesion.

Lastly, an integral part of all social movements is the continual formation, redefinition, and communication of meanings associated with key movement objectives. Goldner,52 in her analysis of key CAM stakeholders, compared organizational and activist responses to outcomes related to avoidance, acquiescence, compromise, manipulation, and defiance to illustrate the differing frames of reference each set of players brings to the table.
Potential sociological linkages

Having briefly outlined explicit examples of CAM-related sociological research, we now consider how more general findings related to CAM modalities and their use may be usefully viewed within established sociological frameworks. Given the limited scope, our intent is not to be exhaustive or overly detailed, but rather to briefly postulate potential connections of empirical observations to key sociological constructs.

Self-care as meaningful labor. Marxian scholars contend that today’s medical system reproduces the economic subversion of the lower classes (i.e., individuals with less education, lower incomes, etc.) by creating a dependence on elites for medical care.65 This dominance, it is argued, is legitimized in part through a false mystique surrounding medical knowledge, making doctors appear to have extraordinary skills that set them apart from “ordinary” people.

The “necessity” of this technical expertise, it could be argued, is indirectly challenged by CAM practitioners, many of whom may more actively involve individuals in their own health care.66 In addition, CAM may offer patients a second, more personal benefit: the satisfaction of their labor. In a Marxian framework, labor (or work) is a natural and essential part of humanity that forms the basis of individuals’ social identities and feelings of self-worth.65 Social systems go awry when individuals are forcibly distanced or even removed from the various aspects of production, leading to “alienated” persons who, lacking control over their environment, can no longer reap any intrinsic benefit from their efforts.

In this framework, personal health may be considered both a form and product of one’s labor. In seeking care, CAM users actively learn “self-care methods,” gain “empowerment,” and participate in “the healing process, time, and personal attention” that is often lacking in today’s allopathic medical model.66 Indeed, CAM users are presumed to exercise their individual agency to make decisions about what they should or should not do with their own health,65 including the acquisition of new health-related skills, behaviors, and even philosophies.68

Social meanings of health care. As noted, the decision to use CAM often transcends physical relief, and is strongly connected to underlying values of holism, mind–body–spiritual connectedness, high-level wellness, energy flow, and cooperative, active healing.27 Moreover, the core beliefs of alternative medicine “build on strong, traditional American values such as individualism, personal responsibility, and a belief in God and the possibility of transcending one’s problems.”69 The greater the salience of these values and beliefs to individuals, the better the “fit” of complementary or alternative medicine.

Like all persons, users of CAM modalities are continually engaged in the process of self-development. When deciding what forms of health/medical care to seek, an individual may temporarily “step out” from his/her own social identity and project the circumstances or judgment on relevant family, friends, co-workers, or the general community.33 Depending on the reference group, the use of CAM therapies may be supported, opposed, or undifferentiated. Indeed, Palinkas et al.3 found that 25.9% of self-identified CAM users chose a therapy on the recommendation of their friends or co-workers, revealing the importance of others’ beliefs on individual behavior.

The notion of “impression management” describes how people consciously act in ways that control others’ views of them. For example, Ray70 found that approximately 24% of American adults are “cultural creatives,” sharing beliefs or interests in ecological sustainability, the exotic and foreign, women’s issues, and inner life/spirituality and social optimism. Bound by the central belief that “body, mind, and spirit should be unified,” cultural creatives are thought to constitute “the core market for psychotherapy, alternative health care, and natural foods.”70

The bureaucractization of medical care. As noted, a potential attraction of CAM is the availability of therapies that do not require the continual oversight of a practitioner (e.g., intercessional prayer, yoga, multivitamin supplements, etc.). Such self-based care allows individuals to choose a form of therapy, to decide when to begin treatment, and to determine its duration. Another possible benefit of many self-based therapies is that they eliminate or greatly reduce the bureaucratic “red tape” (e.g., paperwork, HMO regulations, etc.) associated with allopathic medical care, and the person-alization that frequently ensues.

The U.S. health care system retains the most expensive and complex administrative structures in existence.21 Equally as costly, however, is the range of potentially detrimental psychosocial impacts on both patients22,27 and physicians.73 According to Mechanic,72 one of the most dramatic impacts in the United States is the not-so-gradual erosion of social and interpersonal trust in medicine and medical providers, respectively, related to managed care. While the commercialization of medical care, financial conflicts of interests of managed care plans, and media attention to medical uncertainty and error all undermine social trust in the institution of medicine, the resulting erosion of interpersonal trust in providers impacts the degree to which patients see their physicians as competent, responsible, and caring.22

Lastly, many practitioner-based CAM therapies are hands-on; acupuncture, chiropractics, and therapeutic massage necessitate physical contact between the therapist and the individual seeking relief and wellness. Distinct from the actual treatment, this physical touch alone can have a comforting and healing effect that may also improve the individual’s well-being. Because many health maintenance organizations provide no or only limited coverage of complementary and alternative therapies, the paperwork accompanying CAM visits is usually minimal and focuses on the individual’s background and complaint, rather than on repetitive payment or reimbursement information.

Discussion

Although Kessler et al.74 note that CAM use today “is the result of a secular trend that began at least a half century ago,” many treatments deemed “complementary” to or “alternatives” of allopathic medicine have existed for hundreds and even thousands of years and constitute unique systems
of medicine built upon complex philosophies of health, balance, and well-being (for example). As a result, it is likely that the heightened “popularity” of these diverse modalities is due to some combination of increased availability, visibility, acceptance, effectiveness and, ultimately, utilization.

Yet, because any medical system is socially grounded in the context of time and culture, others have linked the growth in CAM treatments to “general societal changes rather than specific reasons internal to medicine,”72 such as “shifts in medicine’s institutional authority in a consumer-driven health care environment.”70 In contrast, others have emphasized the degree of agency (i.e., personal control) exercised by individuals in their own health care.69

For example, research suggests that CAM use, in part, results from individuals seeking direction over their own health,3,37 even to the point of assuming some risk.32 For many, the decision to adopt CAM therapies reflects a “personal responsibility for health,”77 and constitutes a rational, purposeful attempt to regain some level of personal control.51 Studies have further shown that providers who are seen as more amenable to shared decision-making,78 communicating in a patient-centered fashion,79 listening to their patients’ concerns,80 and recognizing patients’ nonverbal cues are viewed as delivering more satisfying care.81

As shown, the implications of culturally derived meanings for individuals’ definitions of82 and decisions to use CAM therapies15,42,51,83 highlight the importance of values and the social identities they reinforce. One such motivator is what Astin calls the “philosophical congruence” between the individual’s worldview and CAM therapies.1 Indeed, researchers have found that 15% and 17% percent of all CAM users, respectively, cited “philosophical reasons” and preferences “to deal with problem themselves” as reasons for seeking CAM therapies,3 suggesting that certain value structures or “health lifestyles” are closely aligned with CAM therapies.84 Again, these may entail epistemic beliefs regarding disease, cultural meanings associated with mind-body connectedness, holistic approaches to health, or simply a desire for intimate, sustained contact with a healer.51,70

Since a majority of CAM users also use allopathic treatments,16 the former may fill a perceived void in the latter. For example, studies have established the attendance to patients’ emotional needs as an important aspect of care.55 Although verbal and nonverbal communication skills are increasingly emphasized in allopathic training, many physicians may continue to exercise “affective neutrality.”56 For those who view emotions as central to the healing process, CAM providers’ approaches may be more consistent with patients’ preferences.

Finally, sociological work in the areas of institutional power,87 medical dominance,6,88 and medical bureaucracy6,88 illustrate the potentially dehumanizing effects on patients of a complex medical bureaucracy. Ironically, the skyrocketing cost of U.S. health care is often attributed to the use of specialized, high-tech medicine when, in reality, many patients prefer a holistic approach to their health and wellness.64,90 In addition, because approximately one quarter of total costs stem directly from administration (not actual service delivery)91, primary care physicians spend, on average, nearly one half of their time on work outside the examination room,92 thus contributing to their professional discontent.93

Several limitations to this discussion should be mentioned. First, our selection of material was intended solely for purposes of illustration, not as an exhaustive review. Similarly, we have not engaged in a detailed exploration or critique of the theoretical perspectives themselves, nor have we addressed the efficacy of CAM treatments and modalities as factors impacting their use. Second, patient involvement in allopathic care is changing, with such topics as communication, professionalism, and cultural competency now emphasized in allopathic training.

Third, as previously alluded to, we have recognized the pitfalls of defining “CAM” as a homogeneous aggregate when, in fact, tremendous variation exists among modalities, medical systems, and underlying health philosophies.27 Although we have tried to avoid language that neglects this diversity, this may not have been completely clear in some instances. Lastly, in discussing “complementary” or “alternative” care, we must acknowledge the relativism of our own vantage point. As Cassidy94 has pointed out, the inherent ethnocentrism of defining modalities or systems of medicine “unconventional” or “alternative” depends on the established norm, which is not always Western biomedicine.

Conclusions

Like the diversity of modalities, philosophies, and medical systems encompassing CAM, sociology entails a range of theoretical perspectives from which to examine the impacts of external social forces (structure) on individuals (agency). In this paper, we have attempted to illustrate the utility of such approaches to understanding complex social phenomena by providing examples of real and potential applications of sociology to CAM modalities and their use.

Echoing advocates for including “system-level phenomena” into explanatory models of CAM use,95 we believe the social, economic, and cultural contexts within which behaviors occur should not be overlooked. Just as alternative pathways exist in patients’ decisions whether or not to use CAM therapies63 and practitioners lobby for an integration of allopathic and unconventional medicines,96,97 “the evolving process of integration between CAM and conventional medicine evokes new conceptual frameworks.”95 Sociology, we believe, is well suited to making a contribution to understanding the societal forces that influence individual health behaviors, such as the use of CAM therapies.

References


Address reprint requests to:
Terry D. Stratton, Ph.D.
University of Kentucky College of Medicine
Leader Avenue Building, Room 208
138 Leader Avenue
Lexington, KY 40506-9983

E-mail: tdstra00@email.uky.edu
This article has been cited by:

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